Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRA SPECIALTY GROUP PA
8108 FOX CREEK TRAIL
DALLAS TX 75249

Respondent Name
ACIG INSURANCE CO

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-12-0593-01

MFDR Date Received
October 24, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please not that all MAR fee guidelines have been followed. The treatment procedures were properly documented with adequate support and the billings of treatment procedures were not global. Dr. Ericksen was the approved treating doctor and our clinic is an approved HCP. All the medical services provided to the patient were applied to the compensable injury area and were medically necessary.""

Amount in Dispute: $5,901.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a position summary along with the DWC060 response.

Response Submitted by: ACIG c/o Nova Pro Risk Solutions

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2010 through February 8, 2011	Chronic pain management program and drug testing	$5,908.10	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative code §134.203, applies to professional medical services provided on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 3, 2011

- B13 – Payment for service may have been previously paid
- R01 – Duplicate billing

Explanation of benefits dated January 12, 2011

- 125 – Denial reduction due to submission billing error
- RM7 –Invalid code for CMS payment-resubmit w/valid code

Issues

1. Did the insurance reimburse the requestor for the preauthorized chronic pain management?
2. Did the requestor submit documentation to support the billing of CPT code 80101?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the documentation submitted by the insurance carrier supports payment of the chronic pain management program, plus interest for dates of service October 28, 2010 through February 8, 2011, therefore resolving the dispute over the chronic pain management services. No further reimbursement is recommended.
2. Review of all the medical documentation submitted by the requestor, does not include documentation for disputed CPT code 80101-drug testing. Therefore, the division is unable to determine if the services billed were rendered by the requestor. Reimbursement cannot be recommended for the drug testing charge of $201.10.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 22, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.